1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The [illegible] copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07957

CERTIFICATE OF DEATH

07959

Reg. Dist. No. 33

1. PLACE OF DEATH

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 213 Davis St

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

STREET ADDRESS (If rural give location): 213 Davis St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARY	ELIZABETH	ADKINS	JULY	5th	19 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Nov. 6, 1883	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	at Home	Quantico Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Franklin Rider	Kathryn Fessler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
		Mr. Edgar S. Adkins (Husband) 213 Davis St Salisbury, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X IMMEDIATE CAUSE (A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 38

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19 48, to 7/5, 19 57, that I last saw the deceased alive on 7/7, 19 57, and that death occurred at 7:45 P.M. from the causes and on the date stated above.

SIGNATURE Dr. Fred Grange — Fred H. Grange M.D. — ADDRESS (Street, city, town, state) S. Division St. Salisbury, Md — DATE SIGNED July 8 /57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 8, 1957	Parsons Cemetery	Salisbury, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JUL 10 19 57	Mary K. Holloway	HOLLOWAY & COMPANY — SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08016 **CERTIFICATE OF DEATH** 07958

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Chestnut

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Delmar
d. STREET ADDRESS: 1 Chestnut
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virgil; Middle: M.; Last: Adkins

4. DATE OF DEATH: Month: July; Day: 12; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 28, 1879

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Asbury Adkins

14. MOTHER'S MAIDEN NAME: Mary Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --------

16. SOCIAL SECURITY NO.:

17. INFORMANT: Rosa Adkins, Address: Delmar, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: few hours
DUE TO (b): Chronic Myocarditis — 4 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
434.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1957, to July 12, 1957, that I last saw the deceased alive on July 12, 1957, and that death occurred at 6 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. H. Lynch, M.D. — ADDRESS (Street, city or town, state): Delmar Del — DATE SIGNED: July 14 '57

PHYSICIAN'S NAME (Type): S. H. Lynch — Delmar Del

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-15-57

22c. NAME OF CEMETERY OR CREMATORY: Farlows

22d. LOCATION (City, town, or county) (State): Pittsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Mamel Co — ADDRESS: Delmar, Del

24a. REC'D BY REGISTRAR DATE: JUL 16 '57

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The both copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07960 (07959)

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place) 4 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

STREET ADDRESS (If rural, give location) 12 1 Evans St

3. NAME OF DECEASED (Type or Print) (First) Lillian (Middle) Backett (Last)

4. DATE OF DEATH (Month) 7 (Day) 5 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	C	Widowed	Sept 10, 1884	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker	None	Md	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Levin Robinson	Lillie Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	None	Wm Backett

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

600.0 IMMEDIATE CAUSE (A) Uremia

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Pyelonephritis chronic

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-1, 19 57, to 7-5, 19 57, that I last saw the deceased alive on 7-1, 19 57, and that death occurred at 4 P.M. from the causes and on the date stated above.

SIGNATURE Wm B Smith M.D. **ADDRESS** (Street, city, town, state) Med Center Sby Md **DATE SIGNED** 7-7-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-7-57	Polks Rd. Cem	Polks Rd Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
7/12/57	Mary Holloway	Bowen McLeod

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmC218 7-29-57 et

07961

CERTIFICATE OF DEATH

07961 331

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 Lake Street Ext.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert Middle: Last: Bradford

4. DATE OF DEATH: Month: July Day: 14 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/9/1892

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Tex Sex Hosp. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Cerebral Thrombosis
DUE TO
(b): Syphilis of CNS
DUE TO
(c):

026X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 5, 19 57, to July 14, 19 57, that I last saw the deceased alive on July 13, 19 57, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Carrie I Heakn M.D. ADDRESS (Street, city or town, state): N. Division St DATE SIGNED: 7/18/57

PHYSICIAN'S NAME (Type): Dr CARRIE I HEAKN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/18/57

22c. NAME OF CEMETERY OR CREMATORY: Rock Walking Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Cooke Welch

ADDRESS: 130 Second Street Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: JUL 22 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Calloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07962

07962 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City 21842
d. STREET ADDRESS: 803 Second Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Attie Byrd Chesser; Middle; Last: Bunting

4. DATE OF DEATH: Month: July; Day: 3rd; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 2, 1877

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oliver Chesser

14. MOTHER'S MAIDEN NAME: Mollie Byrd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: George O. Bunting, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Arteriosclerotic Cardio Vascular
DUE TO (c): Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1 5811X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cholecystitis and Choledocolithiasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3, 1957, to July 3, 1957, that I last saw the deceased alive on July 3, 1957, and that death occurred at 4:40 p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D. — ADDRESS (Street, city or town, state): 224 N. Division St. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Thomas C. Hill, Jr. Salisbury Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-6-57

22c. NAME OF CEMETERY OR CREMATORY: Nelson Cemetery

22d. LOCATION (City, town, or county) (State): Rural Pocomoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry Ford Watson — ADDRESS: Pocomoke, Md.

24c. REC'D BY REGISTRAR — DATE: JUL 8 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The both copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07963

07963 CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 322 Naylor St

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

STREET ADDRESS (If rural give location): 324 Naylor St.

3. NAME OF DECEASED (Type or Print): (First) LAURA (Middle) ELLEN (Last) CALLAWAY

4. DATE OF DEATH: (Month) July (Day) 1 st (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed	Jan. 23, 1864	93 yrs.	5	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	None	Sussex Co. ~~MARYLAND~~ Delaware	U S A

13. FATHER'S NAME: Jonathan Beach

14. MOTHER'S MAIDEN NAME: Mary Ellen Gordy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No			Mrs. J. Howard Dryden (Daughter) 322 Naylor St. Salisbury, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X IMMEDIATE CAUSE (A): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B): Cerebral arteriosclerosis — 7

DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
334X		YES ☐ NO XX

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not While at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 31, 19 57, to July 1, 19 57, that I last saw the deceased alive on June 31, 19 57, and that death occurred at 2:00A. M. from the causes and on the date stated above.

SIGNATURE Dr. William Gray — William A Gray M.D.

ADDRESS (Street, city, town, state): Camden Ave. - Salisbury, Md.

DATE SIGNED: July 1 /57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 3, 1957	Parsons Cemetery	Salisbury, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JUL 5 1957	Mary T. Holloway	HOLLOWAY & COMPANY - SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07964 (Reg. Dist. No.) 07964 331

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 410 Patterson Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 410 Patterson Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle HENRY Last CALLOWAY

4. DATE OF DEATH: Month July Day 31 st Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 1, 1872
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months 6 Days 30
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Cement Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Georgetown, Delaware
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Calloway
14. MOTHER'S MAIDEN NAME: Sarah Rogers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Bertha Calloway (Wife) Address: 410 Patterson Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
DUE TO (b): Degenerative Heart Disease — 5 yr.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 434.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956 to July 31, 1957, that I last saw the deceased alive on July 30, 1957, and that death occurred at 1:15 P.M., from the causes and an the date stated abave.

ACTUAL SIGNATURE: Earl M Beardsley M.D. ADDRESS (Street, city or town, state): Salisbury Md DATE SIGNED: Aug. 2 1957

PHYSICIAN'S NAME (Type): EARL M. Beardsley Md. Ave - Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 3, 1957
22c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
22d. LOCATION (City, town, or county) (State): Laurel, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: AUG 5 1957
24b. REGISTRAR'S SIGNATURE: Mary L. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08017

CERTIFICATE OF DEATH

07965

Reg. Dist. No. 331

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 1 (Fruitland) St Luke Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Salisbury
d. STREET ADDRESS: R.D.# 1 (Fruitland) St Luke
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
IRVINE	PURNELL	CAUSEY	JULY	21 st	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	August 27,1888	68 yrs.	10	24		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Farming	Worcester Co. Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Causey	Annie Hitch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Unk		Mrs. Agnes Causey (Wife) R.D.# 1 (St. Luke Rd Fruitland) Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

331X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1957, 19____, to 7-21-57, 19____, that I last saw the deceased alive on 7-21-57, 19____, and that death occurred at 7:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lee Lawry M.D. — ADDRESS (Street, city or town, state): Fruitland Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Lee Lawry — Fruitland, Maryland — July 22 1957

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	July 24,1957	Sullen Cemetery	(St.Luke-Wico Co. Near Fruitland, Md.)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.	JUL 25 1957	Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G218 7-22-57 et.

08018

07966

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury Rwatt 2
c. LENGTH OF STAY IN 1b: 8 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Daisey Lee Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill 23x02
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lause — Middle: F. — Last: Ackerman

4. DATE OF DEATH: Month: July — Day: 12 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 23 1879

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pittsville Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Merritt

14. MOTHER'S MAIDEN NAME: Priscilla Ayers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Ralph Harris — Address: Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

331x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/5, 1957, to 7/12, 1957, that I last saw the deceased alive on 7/12/57, 19, and that death occurred at 8:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. R. Pearce M.D.
ADDRESS (Street, city or town, state): Salisbury, Md
DATE SIGNED: 7/13/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 14/57
22c. NAME OF CEMETERY OR CREMATORY: Methodist
22d. LOCATION (City, town, or county): Stockton (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Clay E. Timmons
ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR DATE: JUL 15 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Dallaway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07967 334

08019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 2 (Shad Point) Box# 225

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Salisbury (Rural)
d. STREET ADDRESS: R.D.# 2 (Shad Point) Box # 225
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LANDONIA Middle: GRAY Last: COLONIA

4. DATE OF DEATH: Month: July Day: 15 th Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 25, 1884

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months 9 Days 20 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work at home

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Virginia (Greenbackville)

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Gordon Pilchard

14. MOTHER'S MAIDEN NAME: Louisiana Louisiana Redden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Henry E. Colona (Husband) Address: R.D.# 2 (Shad Point) Box# 225 Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 months

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension C.V. Disease — years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 434.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-2, 1957, to 7-15, 1957, that I last saw the deceased alive on 7-14, 1957, and that death occurred at 11:25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl L Royer M.D.

ADDRESS (Street, city or town, state): Camden Ave. Salisbury, Maryland DATE SIGNED: July 16 /57

PHYSICIAN'S NAME (Type): Dr. Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 18, 1957

22c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery

22d. LOCATION (City, town, or county) (State): R.D.# Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: JUL 18 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07965 — 07968 — Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 4 DAYS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: ACCOMACK.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHINCOTEAGUE 83X-3
d. STREET ADDRESS: 111 COLONA ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

82

3. NAME OF DECEASED (Type or print): First MARY — Middle — Last COLONA
4. DATE OF DEATH: Month July — Day 28 — Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 5 1882
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chincoteague, Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Daisey
14. MOTHER'S MAIDEN NAME: Mariah Thornton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: Mrs. Anne Mason, Pocomoke, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Coronary Artery Heart Disease — 3 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial Insufficiency — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
260X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/24, 1957 to 7/28, 1957, that I last saw the deceased alive on 7/28, 1957, and that death occurred at 10:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: July 30, 1957
PHYSICIAN'S NAME (Type): David J. Gilmore — Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/31/57
22c. NAME OF CEMETERY OR CREMATORY: Beulah
22d. LOCATION (City, town, or county) (State): Chincoteague Va

23. FUNERAL DIRECTOR'S SIGNATURE: Walter M. Ebert — ADDRESS: Chincoteague Va
24a. REC'D BY REGISTRAR DATE: 7-30-57
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07969

07966

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Salisbury - R 70 #4
d. STREET ADDRESS: Snow Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jesse Middle: Last: Corbin

4. DATE OF DEATH: Month: July Day: 25 Year: 1957

5. SEX: male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 3- 1884

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-32-1181

17. INFORMANT: Linwood Corbin Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Benign hypertrophy of the prostate — years
DUE TO
(c): Right pyelonephritis. — weeks

610x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-6-57, 19____, to 7-25-57, 19____, that I last saw the deceased alive on 7-25-57, 19____, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl L Royer M.D.
ADDRESS (Street, city or town, state): 407 Camden Ave, Salisbury, Md.
DATE SIGNED: 7-26-57

PHYSICIAN'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-29-57
22c. NAME OF CEMETERY OR CREMATORY: Green Acres Memorial
22d. LOCATION (City, town, or county): Salisbury (State): md

23. FUNERAL DIRECTOR'S SIGNATURE: Bunkie M. West
ADDRESS:
24a. REC'D BY REGISTRAR DATE: AUG 1 1957
24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG218 7-30-57 et

CERTIFICATE OF DEATH

08020 — 07979 — Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
c. LENGTH OF STAY IN 1b: 50yrs
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X / Willards RFD

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: XX
d. STREET ADDRESS: / XXXXX
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ANNIE — Middle S. — Last DAVIS
4. DATE OF DEATH: Month July — Day 22 — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ X Widowed DIVORCED ☐
8. DATE OF BIRTH: March 25 1867
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Esham
14. MOTHER'S MAIDEN NAME: Sarah Magee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): XX — (If yes, give war or dates of service): XX
16. SOCIAL SECURITY NO.: xxx
17. INFORMANT: Mr. Walter Davis — Address: Willards, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Liver — INTERVAL BETWEEN ONSET AND DEATH
156.1
DUE TO
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b): Chr. Myocarditis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 4 1957, to July 22 1957, that I last saw the deceased alive on July 21 1957, and that death occurred at 6P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. R. Parr M.D. — ADDRESS (Street, city or town, state): Berlin Md — DATE SIGNED: 7-23-1957

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): 7/24/57
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: New Hope
22d. LOCATION (City, town, or county) (State): Willards Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley — ADDRESS: Sellgrude Del
24a. REC'D BY REGISTRAR DATE: JUL 25 1957
24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07967 **CERTIFICATE OF DEATH** 07971 332

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3½ hours
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock 09x12
d. STREET ADDRESS: Near Williamsburg
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Benjamin; Middle; Last Davis

4. DATE OF DEATH: Month July; Day 10; Year 1957

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: June 19, 1883

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Davis

14. MOTHER'S MAIDEN NAME: Krusha Meekins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary thrombosis	10 min.
DUE TO		
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost. 420.1 — DUE TO (b)	Arteriosclerotic cardiovascular disease	?
DUE TO (c)	Arteriosclerosis, general	?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Left hemiplegia due to Cerebral thrombosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 10, 1957, to July 10, 1957, that I last saw the deceased alive on July 10, 1957, and that death occurred at 2 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: V Juerman. M.D. ADDRESS (Street, city or town, state): Deer's Head State Hospital DATE SIGNED: 7/10/57

PHYSICIAN'S NAME (Type): V. Juerman, M. D. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 13, 1957

22c. NAME OF CEMETERY OR CREMATORY: Washington Cemetery

22d. LOCATION (City, town, or county) (State): Near Hurlock, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J J Frampton Son — ADDRESS: Federalsburg md

24a. REC'D BY REGISTRAR DATE: 7-12-57

24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

.C8021

Reg. Dist. No. 07972 334

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Powellville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# Pittsville,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Powellville (Rural)
d. STREET ADDRESS: 1 R.D.# Pittsville
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN — Middle VALENTINE — Last DENNIS

4. DATE OF DEATH: Month JULY — Day 13 th — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]: Single

8. DATE OF BIRTH: October 22, 1883

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months 8 Days 21
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Powellville, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Marcellus Dennis

14. MOTHER'S MAIDEN NAME: Laura Ann Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Robert A. Dennis (Brother) Address: R.D.# Pittsville - Powellville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronco-pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension — 3-5 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1952, 19, to day of death, that I last saw the deceased alive on 7-12, 1957, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Lewis M.D. ADDRESS (Street, city or town, state): Willards, Maryland DATE SIGNED: 7-16-57.

PHYSICIAN'S NAME (Type): Dr. Frank R. Lewis — July 14 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 15, 1957

22c. NAME OF CEMETERY OR CREMATORY: Dennis Family Cemetery

22d. LOCATION (City, town, or county) (State): R.D.# Pittsville-Powellville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: JUL 17 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8022

Reg. Dist. No. 07973

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Siloam
c. LENGTH OF STAY IN 1b: 19 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Eden Rt #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Siloam
d. STREET ADDRESS: 1 Eden Rt #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First LAWRENCE; Middle DAVIS; Last DENSON

4. DATE OF DEATH: Month 7; Day 7; Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Oct. 4,1904

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Farming

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ephrem A. Denson

14. MOTHER'S MAIDEN NAME: Emma Lawrence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 220-34-9972

17. INFORMANT: Mrs. Lua Denson, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Hrs.
420.1
DUE TO:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/10, 19 56 to 7/7, 19 57, that I last saw the deceased alive on July 7, 1957, and that death occurred at 2 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E M Beardsley, M.D.
ADDRESS (Street, city or town, state): Salisbury. Maryland
DATE SIGNED: 7/8/1957

PHYSICIAN'S NAME (Type): E.M. Beardsley, 207 Maryland Ave., Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/10/57
22c. NAME OF CEMETERY OR CREMATORY: Siloam Cemetery
22d. LOCATION (City, town, or county) (State): Siloam, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Hill & Johnson Co. Salisbury, Maryland
Norman F. Baker

24a. REC'D BY REGISTRAR DATE: 7-10-57
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07968

CERTIFICATE OF DEATH

07974

Reg. Dist. No. 331

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 26 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury, Maryland
d. STREET ADDRESS: 513 Wicomico Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Carl; Middle: Fleetwood; Last: Disharoon

4. DATE OF DEATH: Month: July; Day: 6; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 15, 1877

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --Used Furnature Dealer

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): West Post Office, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Marcellus Disharoon

14. MOTHER'S MAIDEN NAME: Ellen Pusey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk.
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 213-24-4983A

17. INFORMANT: Mr. Howard W. Disharoon (Son) Address: 513 Wico. St. Sal. Md
Deer's Head Hospital Records, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 days
420.0
DUE TO (b): Arteriosclerotic heart disease — -- ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 422.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 19 57, to July 6, 19 57, that I last saw the deceased alive on July 6, 19 57, and that death occurred at 12:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve, M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 7/6/57

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 9, 1957
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: JUL 10 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08025 — Reg. Dist. No. 07975 332

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D.# 1(Near Fruitland)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Salisbury
   d. STREET ADDRESS: 1 R.D.# 1(Near Fruitland)
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle ROY — Last ENNIS

4. DATE OF DEATH: Month JULY — Day 29th — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Feb. 16, 1898

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months 5, Days 13 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming on Farm

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Worcester Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles Edward Ennis

14. MOTHER'S MAIDEN NAME: Clarissa Jane Smullen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ella L. Ennis(Wife) Address R.D.# 1(Near Fruitland) Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden.

4.20.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Earl L Royer M.D. — CHIEF MEDICAL EXAMINER [ ] — ASSISTANT MEDICAL EXAMINER [ ] — DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Dr. Earl.L. Royer

DATE SIGNED: July 30 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug.1, 1957

22c. NAME OF CEMETERY OR CREMATORY: Smullen Cemetery (St. Luke-Worcester Co. Maryland

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR — DATE: AUG 1 1957

24b. REGISTRAR'S SIGNATURE: Mary K Holloway

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07969 **CERTIFICATE OF DEATH** Reg. Dist. No. 07976 33r

1. PLACE OF DEATH
a. COUNTY: W icomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cloverdale Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 Cloverdale Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSA — Middle ETTA — Last FARLOW

4. DATE OF DEATH: Month July — Day 14 th — Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 1, 1873
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months 4 — Days 13
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): R.D.# Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Wesley Parker
14. MOTHER'S MAIDEN NAME: Laura Ann Maddox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Clyde B. Hastings (Daughter) Address: Cloverdale Road Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
434.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 16 to 7-14-57, 19, that I last saw the deceased alive on 7-14-57, 19, and that death occurred at 5:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lee L Lawry M.D. M.D. — ADDRESS (Street, city or town, state): Fruitland, Md — DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Lee Lawry — Fruitland, Maryland — July 17, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 17, 1957
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: JUL 18 1957
24b. REGISTRAR'S SIGNATURE: Mary W Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07970 07977

CERTIFICATE OF DEATH

Reg. Dist. No. 331

Husband-Wm J. Gordy Jr.(Deceased)

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 403 Park Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 403 Park Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle CLARA — Last GORDY

4. DATE OF DEATH: Month JULY — Day 15 th — Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 28,1874

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months 11 Days 17 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John H. White

14. MOTHER'S MAIDEN NAME: Annette Vickers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs.J.Cleveland White(Nephew) Address: 1546 Fleneagle Rd. Zone 12 Baltimore, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic malignant Melanoma — INTERVAL BETWEEN ONSET AND DEATH: 10 Mo

190X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 27, 19 57, to July 15, 19 57, that I last saw the deceased alive on July 15 57, 19, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: D.R. Grause M.D. — ADDRESS (Street, city or town, state): S.Division St. Salisbury,Maryland — DATE SIGNED: July 16 57

PHYSICIAN'S NAME (Type): Dr.Fred Grause

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 17,1957

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY,MD.

24a. REC'D BY REGISTRAR DATE: JUL 18 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

FOR STATE HEALTH DEPT.

M

82

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2

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12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07971

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07978

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg X O d. STREET ADDRESS: R F D # 1 e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Benjamin	Rounds	Hamblin		7-	26	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		July 2, 1885	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Parsonsburg	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph J. Hamblin	Sarah Martha Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
UNK			Mrs. Margaret Hamblin- wife-Parsonsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary embolus: thrombosis iliac vein	Sudden
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Sub-dural hematoma	Days 9
DUE TO (c)		

902.7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	Struck head falling from wheelchair.

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
P p. m.	7-17-57		Hospital	Salisbury	Wicomico	Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

DATE SIGNED: 7-29-57

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7-29-57	Forest Grove Cemetery	Parsonsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Holloway and Co. Funeral Home, Salisbury, Md.	JUL 30 1957	Mary F. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08024

CERTIFICATE OF DEATH

07979
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 89 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 500 Chestnut

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Delmar
d. STREET ADDRESS: 1 500 Chestnut
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eva — Middle: Kathleen — Last: Hastings

4. DATE OF DEATH: Month: July — Day: 9 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 23, 1867

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Wicomico County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hezekiah Hastings

14. MOTHER'S MAIDEN NAME: Mary Hastings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Martha Hastings, Delmar, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia Coma — INTERVAL BETWEEN ONSET AND DEATH: 24 hr
DUE TO (b): Chronic Nephritis
DUE TO (c):

592 ×
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1957, to July 9, 1957, that I last saw the deceased alive on July 9, 1957, and that death occurred at 9:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. H. Lynch M.D. — ADDRESS (Street, city or town, state): Delmar Del — DATE SIGNED: July 11-57

PHYSICIAN'S NAME (Type): S. H. Lynch — Delmar Del

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-11-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive

22d. LOCATION (City, town, or county) (State): Delmar, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. S. Mantel Co-Delmar, Del

24a. REC'D BY REGISTRAR DATE: JUL 15 57

24b. REGISTRAR'S SIGNATURE: W. Leavell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07972

07980 33

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 903 E. Church St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nathaniel — Middle: Franklin — Last: Hobbs

4. DATE OF DEATH: Month: 7 — Day: 23 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-26-1879

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Nathaniel Franklin Hobbs

14. MOTHER'S MAIDEN NAME: Lucy Nickerson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 717-07-9018

17. INFORMANT — Address: Woodrow Hobbs, Clayton, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial degeneration — Interval between onset and death: Years
DUE TO
153X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of the sigmoid — Interval between onset and death: Months
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Expired following surgery for resection of the sigmoid.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7-25-57

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-27-57
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial
22d. LOCATION (City, town, or county) (State): Salisbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles M. Mann
ADDRESS: Shar[illegible]town, Md.

24a. REC'D BY REGISTRAR DATE: 7/30/57
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07973

CERTIFICATE OF DEATH

Reg. Dist. No. 07981 334

1. PLACE OF DEATH
a. COUNTY: Wocimico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 409 Priscilla St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 409 Priscilla St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRIETTA — Middle — Last HOLLOWAY
4. DATE OF DEATH: Month July — Day 19 th — Year 19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		October 26,1868	88 yrs.	8	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work at Home	None	Sussex County Delaware	U S A

13. FATHER'S NAME: Noble C. Baker
14. MOTHER'S MAIDEN NAME: Lavenia Wyatt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Agnes Owens (Daughter) Address 409 Priscilla St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	7 days.
DUE TO (b)	arteriosclerosis	10 yrs.
DUE TO (c)		

331X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Degenerative Heart disease - Congestive Heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 54, to 7/19, 19 57, that I last saw the deceased alive on 7/19, 19 57, and that death occurred at 6:00 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Beardsley M.D.
ADDRESS (Street, city or town, state): Maryland Ave. Salisbury, Maryland
DATE SIGNED: July 20/57
PHYSICIAN'S NAME (Type): Dr. Earl Beardsley

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 21,1957	Forest Grove Cemetery	R.D.# Parsonsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: JUL 22 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07974

CERTIFICATE OF DEATH

07982 Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 wks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Penisula Gen. Hopp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin 23x22
d. STREET ADDRESS: Route # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Alexander; Middle; Last Hudson

4. DATE OF DEATH: Month 7; Day 13; Year 19 57

5. SEX: M

6. COLOR OR RACE: AA

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-29-1892

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Chemical Plant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Purnell

14. MOTHER'S MAIDEN NAME: Mary Hudson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 195-05-5016

17. INFORMANT: Mrs. Selena Hudson, Berlin, Md. Rt #3 (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Generalized arteriosclerosis
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 31, 1957, to July 13, 1957, that I last saw the deceased alive on July 13, 1957, and that death occurred at 1:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Eugene F. Limberg M.D.
ADDRESS (Street, city or town, state): Salisbury Md.
DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-18-1957
22c. NAME OF CEMETERY OR CREMATORY: Germantown Cemetery
22d. LOCATION (City, town, or county) (State): Berlin, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: JUL 19 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items9 FilmG218 7-23-57 et

07975

CERTIFICATE OF DEATH

07983 Reg. Dist. No. 33

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Md.
c. LENGTH OF STAY IN 1b: 1008 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Deer's Head State Hospita l

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury, Maryland
d. STREET ADDRESS: 112 Evans Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel; Middle: ; Lost: Hymn

4. DATE OF DEATH: Month: July; Day: 8; Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 10, 1883

9. AGE (In years last birthday): 7773 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Eastern Shore, Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-20-4842A

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

(b) Arteriosclerotic cardiovascular disease — ? ?

DUE TO

(c) Arteriosclerosis, general

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 446X Nephrosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/4/ 1954, to 7/8/ 1957, that I last saw the deceased alive on 7/8/ 1957, and that death occurred at 1:35 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: V Juerman. M.D.

ADDRESS (Street, city or town, state): Deer's Head State Hospital

DATE SIGNED: 7/8/57

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-12-57

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem

22d. LOCATION (City, town, or county) (State): Delmar Md

23. FUNERAL DIRECTOR'S SIGNATURE: Baker M Cust

ADDRESS:

24a. REC'D BY REGISTRAR DATE: JUL 15 1957

24b. REGISTRAR'S SIGNATURE: Mary L Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07976

07984 337
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 12 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 300 Delaware Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: H. — Last: Jones

4. DATE OF DEATH: Month: 7 — Day: 13 — Year: 1957

5. SEX: F M

6. COLOR OR RACE: AA

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6 14 1871

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elisha Williams

14. MOTHER'S MAIDEN NAME: Louise Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Louise Roberts, 300 Delaware St., Salisbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Degenerative Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO (b): Arteriosclerosis — Indefinite
DUE TO (c):

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 13 May, 1957, to 13 July, 1957, that I last saw the deceased alive on 13 July, 1957, and that death occurred at 9 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Purnell, M.D. — ADDRESS (Street, city or town, State): 652 W. Main Salisbury Md — DATE SIGNED: 16 July 57

PHYSICIAN'S NAME (Type): Dr. E. A. Purnell 652 W. Main St., Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-16-1957
22c. NAME OF CEMETERY OR CREMATORY: John Wesley Cemetery
22d. LOCATION (City, town, or county) (State): Deal Island, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md

24a. REC'D BY REGISTRAR DATE: JUL 19 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7977

CERTIFICATE OF DEATH

07985 Reg. Dist. No. 437

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Yrs 1-4
d. STREET ADDRESS: 1017 Valley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ellen; Middle: ; Last: Kearney

4. DATE OF DEATH: Month: July; Day: 12; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/17/1861

9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months ; Days
IF UNDER 24 HRS.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Slava Kearney

14. MOTHER'S MAIDEN NAME: Maria Siree

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis, general — ?
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. ; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 1, 1952, to July 12, 1957, that I last saw the deceased alive on July 12, 1957, and that death occurred at 8:28 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. Vjuerman. M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 7/13/57

PHYSICIAN'S NAME (Type): V. Juerman, M. D.
Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 16, 1957
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: JUL 17 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7978 **CERTIFICATE OF DEATH** 07986 Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 Wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula Gen, Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Tyaskin
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BASIL — Middle E. — Last LARMORE

4. DATE OF DEATH: Month July — Day 18 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/20/1885

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months 8 — Days 28 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: American Can Co. of Philadelphia

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George C.H.Larmore

14. MOTHER'S MAIDEN NAME: Nettie Dickerson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Alice Larmore, Tyaskin , Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19____, to ____, 19____, that I lost saw the deceased alive on 7-21, 1957, and that death occurred at 2 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilbur R. Ellis, Jr. M.D. — ADDRESS (Street, city or town, state): Salisbury, Md — DATE SIGNED: 7-21-57

PHYSICIAN'S NAME (Type): Wilbur R. Ellis, Jr. — Medical Center, Salisbury, Md. 7/21/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/21/57
22c. NAME OF CEMETERY OR CREMATORY: Tyaskin Cem.
22d. LOCATION (City, town, or county) (State): Tyaskin, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. H. Messick — ADDRESS: Bivalve, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 26 1957
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07979 — 07987 — 332

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Spring Hill Private Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne 19x22
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rufus N. — Middle — Last: Layfield

4. DATE OF DEATH: Month: July — Day: 13 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 9, 1882

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Layfield

14. MOTHER'S MAIDEN NAME: Virginia Layfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mrs. Rufus Layfield — Address: Princess Anne, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c):

332x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 350x Parkinsonism (Arteriosclerotic)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 18, 1957 to July 7, 1957 that I last saw the deceased alive on July 10, 1957 and that death occurred at 2:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. — ADDRESS (Street, city or town, state): Salisbury Md. — DATE SIGNED: July 13, 1957

PHYSICIAN'S NAME (Type): David J. Gilmore

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-17-57

22c. NAME OF CEMETERY OR CREMATORY: Manokin Presbyterian

22d. LOCATION (City, town, or county) (State): Princess Anne, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Leon R. Watson — ADDRESS: Princess Anne, Md.

24a. REC'D BY REGISTRAR — DATE: JUL 18 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07988

C7980

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown 14x22
d. STREET ADDRESS: R. F. D. # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nannie; Middle: ; Last: Lindsey

4. DATE OF DEATH: Month: July; Day: 16; Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 20, 1893

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chestertown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Broadway

14. MOTHER'S MAIDEN NAME: Laura Graves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent cerebral hemorrhage with left hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 15 days
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis, general — ?
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 422.1 Arteriosclerotic cardiovascular disease, decompensated

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/28/, 1954, to 7/16/, 1957, that I last saw the deceased alive on 7/15/, 1957, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr V Iverman. M.D.
ADDRESS (Street, city or town, state): Deer's Hea d State Hospital
DATE SIGNED: 7/16/57

PHYSICIAN'S NAME (Type): V. Iverman, M. D.
Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-20-57
22c. NAME OF CEMETERY OR CREMATORY: Janes Cem.
22d. LOCATION (City, town, or county) (State): Chestertown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walley
ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JUL 18 1957
24b. REGISTRAR'S SIGNATURE: Mary A Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07981 — 07989 — Reg. Dist. No. 33r

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pomfret 08x02
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Eulalia — Middle: — Last: Lloyd

4. DATE OF DEATH: Month: July — Day: 10 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 22, 1879

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Pittsburgh, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David K. Davis

14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO: 4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Arteriosclerotic heart disease — ?
(c) DUE TO:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Old CVA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 8, 1957, to July 10, 1957, that I last saw the deceased alive on July 10, 1957, and that death occurred at 1 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve, M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 7/10/57

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 13 1957
22c. NAME OF CEMETERY OR CREMATORY: Monongahela Cemtry
22d. LOCATION (City, town, or county) (State): Braddock Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Hontz Funeral Home — ADDRESS: Waldorf Md

24a. REC'D BY REGISTRAR DATE: JUL 15 1957

24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07990

C7982

Reg. Dist. No. 33

1. PLACE OF DEATH

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 123 West Locust St

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

STREET ADDRESS (If rural give location) 123 West Locust St

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
PURNELL	CORNELIUS	MADDOX	July	4 th	19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	March 20, 1871	86 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auctioneer		Wicomico County Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph M. Maddox	Sarah Martha Shockley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or detes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Unk		Mrs. Cassie M. Maddox (Wife) 123 West Locust St. Salisbury, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 IMMEDIATE CAUSE (A) Cardiac arrest.

ANTECEDENT CAUSE(S) DUE TO (B) Senility

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Coronary thrombosis.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/4, 1956, to July 4, 1957, that I last saw the deceased alive on 7/1, 1957, and that death occurred at 3:45A M, from the causes and on the date stated above.

SIGNATURE Dr. Andrew C. Mittchell M.D. — ADDRESS (Street, city, town, state) Maryland Ave. Office-Salisbury, Md. — DATE SIGNED July 5 /57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 6, 1957	Wicomico Memorial Park	Salisbury, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JUL 8 1957	Mary H. Holloway	HOLLOWAY & COMPANY — SALISBURY MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9: 6218 7983 7/30/57 L

CERTIFICATE OF DEATH

07991 337

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ohio — b. COUNTY: Trumbull
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warren 72x-5
d. STREET ADDRESS: 438 Waverly Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jane (Geny) Middle: Last: Maris
4. DATE OF DEATH: Month: July Day: 10 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 10 1893 1890
9. AGE (In years last birthday): 64 yrs. 3
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Chios Greece
12. CITIZEN OF WHAT COUNTRY? Greece

13. FATHER'S NAME: Kon Falas
14. MOTHER'S MAIDEN NAME: d/o Record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Theodore A. Maris (Son) 438 Waverly Ave. Warren, Ohio — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, acute — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 10, 1957, to July 10, 1957, that I last saw the deceased alive on July 10, 1957, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilbur R. Ellis Jr. M.D. — ADDRESS (Street, city or town, state): Medical Center Salisbury, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Wilber R. Ellis Jr. — July 11, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 14, 1957
22c. NAME OF CEMETERY OR CREMATORY: Chapel Hill
22d. LOCATION (City, town, or county) (State): Weirton, West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: JUL 15 1957
24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7984

CERTIFICATE OF DEATH

07992 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Private Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~KKK~~ Virginia
b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ONANCOCK
d. STREET ADDRESS: Kerr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First FLORENCE Middle Last MILLS

4. DATE OF DEATH: Month JULY Day 8TH Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 30, 1881

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Toronto, Canada

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Francis Sibbald

14. MOTHER'S MAIDEN NAME: Catherine Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. C. W. Newman
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Stroke
334X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertension
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
444X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-7, 19 57 to 7-8, 19 57, that I last saw the deceased alive on 7-8, 19 57, and that death occurred at 1:23 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. William Smith M.D.
ADDRESS (Street, city or town, state): Medical Center Salisbury, Md
DATE SIGNED

PHYSICIAN'S NAME (Type): Wm B Smith Med. Center July 9 57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-10-57

22c. NAME OF CEMETERY OR CREMATORY: ONANCOCK

22d. LOCATION (City, town, or county) (State): ONANCOCK Va

23. FUNERAL DIRECTOR'S SIGNATURE: Carlisle R. Williams
ADDRESS:

24a. REC'D BY REGISTRAR DATE: JUL 11 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Calloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07985

07993

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN 23X22
d. STREET ADDRESS: SOUTH MAIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALFRED Middle RUSSELL Last MITCHELL

4. DATE OF DEATH: Month JULY Day 21 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 18, 1902

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: OWN STORE

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY C MITCHELL

14. MOTHER'S MAIDEN NAME: BELLE SHARP

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-28-3864

17. INFORMANT: MRS. A. R. MITCHELL Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anaplastic Carcinoma (Metastatic) of Brain — INTERVAL BETWEEN ONSET AND DEATH: 2 mos ?
DUE TO (b): Bronchigenic Carcinoma, Left (?) — >12 mos (?)
DUE TO (c):

162x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/17, 1957, to 7/21, 1957, that I last saw the deceased alive on 7/21, 1957, and that death occurred at 10:45 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S. Gardner Jr. M.D. — ADDRESS (Street, city or town, state): 321 S. DIV. ST — DATE SIGNED: 7/21/57

PHYSICIAN'S NAME (Type): RUFUS S. GARDNER JR. Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7/24/57

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: JUL 23 1957

24b. REGISTRAR'S SIGNATURE: Mary W. Hollow

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07986 **CERTIFICATE OF DEATH** Reg. Dist. No. 07994 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 423 Pinehurst Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Private Sanitarium

3. NAME OF DECEASED (Type or print): First: William Middle: S.ydney Last: Moore

4. DATE OF DEATH: Month: 7 Day: 21 Year: 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Apr. 22, 1871
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - Banker
10b. KIND OF BUSINESS OR INDUSTRY: Pres. Bank
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William S. Moore
14. MOTHER'S MAIDEN NAME: Laura Griffin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: None
17. INFORMANT: William S. Moore Jr. Address: Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro - Vasculer accident — INTERVAL BETWEEN ONSET AND DEATH
331 ✕
DUE TO (b): Senility
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on July 20, 1957, and that death occurred at 8:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. C. Mitchell, M.D. ADDRESS (Street, city or town, state): Salisbury, Md. DATE SIGNED: 7-21-57

PHYSICIAN'S NAME (Type): A. C. Mitchell Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/24/57
22c. NAME OF CEMETERY OR CREMATORY: ST. John's Cemetery
22d. LOCATION (City, town, or county) (State): Fruitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Hill & Johnson Co. Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE: 7-23-57
24b. REGISTRAR'S SIGNATURE: Mary M. Holloway

Norman T. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07987 **CERTIFICATE OF DEATH** 07995

Reg. Dist. No. 33

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2. PARSONSBURG
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BRENDA Middle LEE Last MORGAN

4. DATE OF DEATH: Month JULY Day 21 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: APRIL 17, 1956

9. AGE (In years last birthday): 1 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): SALISBURY MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: BENNY MORGAN

14. MOTHER'S MAIDEN NAME: ETHEL TOOMEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MR. BENNY MORGAN, PARSONSBURG MD
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
492x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 344x
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hydrocephalus with Ureteral anastomosis. Maintainpatency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 20, 1957, to July 21, 1957, that I last saw the deceased alive on July 21, 1957, and that death occurred at 5:00 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert H. Sanderson Jr. M.D.
ADDRESS (Street, city or town, state): 926 E Division St
DATE SIGNED: 7/21/57

PHYSICIAN'S NAME (Type): Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/23/57

22c. NAME OF CEMETERY OR CREMATORY: TWILIGHT

22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Bunting
ADDRESS: Berlin Md

24c. REC'D BY (REGISTRAR) DATE: JUL 23 1957

24b. REGISTRAR'S SIGNATURE: Mary A. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07998 **CERTIFICATE OF DEATH** 07996

Reg. Dist. No. 33-1

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 30a.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Delaware — b. COUNTY: Sussex.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frankford. 46 x 3
d. STREET ADDRESS: Thatcher, St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward. Middle: Last: Morris

4. DATE OF DEATH: Month: July Day: 21st Year: 1957.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/4/88

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Earnest G. Morris

14. MOTHER'S MAIDEN NAME: Alice Turner.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 221-22-0005

17. INFORMANT: Minerva Morris — Address: Frankford

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, acute — INTERVAL BETWEEN ONSET AND DEATH: 3days
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-18, 1957, to 7-21, 1957, that I last saw the deceased alive on 7-21, 1957, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willem R. Ellis Jr. M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 7/24/57 — 22c. NAME OF CEMETERY OR CREMATORY: Odd Fellows — 22d. LOCATION (City, town, or county) (State): Bishopville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Watson & Gray — ADDRESS: Frankford, Del.

24a. REC'D BY REGISTRAR DATE: JUL 25 1957

24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07997

07989 **CERTIFICATE OF DEATH**

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDEN
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First — Middle — Last: MORTON
4. DATE OF DEATH: Month: July — Day: 27 — Year: 1957

5. SEX: MALE
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 27, 1957
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours: 1 — Min.: 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES WILLIAM MORTON.
14. MOTHER'S MAIDEN NAME: EVELYN Hughes.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO
776x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS ~~CONTRIBUTING TO DEATH BUT NOT~~ RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 27, 1957, to July 27, 1957, that I last saw the deceased alive on July 27, 1957, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Herbert Sembly M.D. — ADDRESS (Street, city or town, state): 400 E. Church St. Salisbury Md — DATE SIGNED: 7/28/57

PHYSICIAN'S NAME (Type): G. Herbert Sembly

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 7-30-57.
22c. NAME OF CEMETERY OR CREMATORY: Peninsula General Hospital
22d. LOCATION (City, town or county) (State): SALISBURY Wicomico Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Peninsula General Hospital
24a. REC'D BY REGISTRAR DATE: 7-30-57
24b. REGISTRAR'S SIGNATURE: Mary W Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

20822366XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07998 332

07990 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton 07x02
d. STREET ADDRESS: R # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Henry — Last: Nedab

4. DATE OF DEATH: Month: July — Day: 12 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1875

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?

10b. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): Chincoteague, Va

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hezekiah Nedab

14. MOTHER'S MAIDEN NAME: Elizabeth Creek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1
(b): Arteriosclerotic cardiovascular disease — ?
DUE TO
(c): Arteriosclerosis, general — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 177 Ca. of prostate gland with metastases

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/11/ 19 57, to 7/12/57 19 ____, that I last saw the deceased alive on 7/12/ 19 57, and that death occurred at 10:17 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. V. Fuerman. M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 7/12/57

PHYSICIAN'S NAME (Type): V. Fuerman — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 7-13-57

22c. NAME OF CEMETERY OR CREMATORY: Westminster Bd

22d. LOCATION (City, town, or county) (State): Balto City Md

23. FUNERAL DIRECTOR'S SIGNATURE: Parker Hearst — ADDRESS:

24a. REC'D BY REGISTRAR DATE: 7/18/57

24b. REGISTRAR'S SIGNATURE: Mary L. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07991 07999

Reg. Dist. No. 33

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Worcester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury c. LENGTH OF STAY IN 1b: 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke 2342.2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital	d. STREET ADDRESS: Box 42 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First William Middle A. Last Northcutt	4. DATE OF DEATH: Month 7-24-57 Day Year 19
5. SEX: M	6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: May 6, 1925
9. AGE (In years last birthday): 32 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic	10b. KIND OF BUSINESS OR INDUSTRY: Garage
11. BIRTHPLACE (State or foreign country): South Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James A. Northcutt	14. MOTHER'S MAIDEN NAME: Lizzie Jenkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 256-28-8201
17. INFORMANT Address: Mrs Pauline Northcutt, Pocomoke, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Compression fracture C-5	3 days
DUE TO (b)	Severed cervical cord	3 days
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

902.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Dove into 2½ ft. of water and struck head on sand bar.

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
7-21-57 19		Merrills Beach	Pocomoke	Worcester	Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

DATE SIGNED: 7-25-57

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 30, 1957	Bascom Cemetery	Hilltonia, Georgia

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson ADDRESS: Pocomoke, Md.

24a. REC'D BY REGISTRAR DATE: JUL 29 19

24b. REGISTRAR'S SIGNATURE: Mary A. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07992

CERTIFICATE OF DEATH

08000 331

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanticoke
d. STREET ADDRESS: General Delivery
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Luther; Last: Nutter

4. DATE OF DEATH: Month: 7; Day: 23; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: AA

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 7, 1907

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Resturant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel H. Nutter

14. MOTHER'S MAIDEN NAME: Annie Horner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-16-6927

17. INFORMANT: Mrs. Evelyn Nutter, Nanticoke, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Portal Cirrhosis of the Liver — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
581.0
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastrointestinal Hemorrhage
578.9
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m.; Month; Day; Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 12, 19 57 to July 23, 19 57, that I last saw the deceased alive on July 23, 19 57, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D.
ADDRESS (Street, city or town, state): Salisbury, Md.
DATE SIGNED: July 26, 1957

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-27-57

22c. NAME OF CEMETERY OR CREMATORY: Nanticoke Cemetery

22d. LOCATION (City, town, or county) (State): Nanticoke, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md

24a. REC'D BY REGISTRAR DATE: JUL 31 1957

24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07993

CERTIFICATE OF DEATH

08001

Reg. Dist. No. 332

1. PLACE OF DEATH

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

STREET ADDRESS (If rural give location): 104 Wade St.

3. NAME OF DECEASED (Type or Print): (First) SALLIE (Middle) (Last) POPE

4. DATE OF DEATH: (Month) JULY (Day) 7th (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
					Months	Days	Hours	Min.
Female	White	Widowed	August 31,1870	86 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House work at Home	None	Somerset Co. Maryland	U S A

13. FATHER'S NAME: Irving Hitch

14. MOTHER'S MAIDEN NAME: Sarah Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Minnie Muir (Daughter) 104 Wade St. Salisbury, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332 X

IMMEDIATE CAUSE (A): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSE(S) DUE TO (B): Cerebral Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
334 X		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 19 57, to July 7, 19 57, that I last saw the deceased alive on July 7, 19 57, and that death occurred at 6:30P.M., from the causes and on the date stated above.

SIGNATURE AND TITLE OF CERTIFIER: Dr. William Gray — William Gray M.D.

ADDRESS (Street, city, town, state): Camden Ave. Salisbury, Maryland

DATE SIGNED: July /57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 10,1957	Parsons Cemetery	Salisbury, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JUL 11 1957	Mary H. Holloway	HOLLOWAY & COMPANY — SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7994

CERTIFICATE OF DEATH

08002 Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill Route #2
d. STREET ADDRESS: 23x02
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lena — Middle: R. — Last: Powell

4. DATE OF DEATH: Month: July — Day: 22 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug 1-1894

9. AGE (In years last birthday): 62/11/22 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Snow Hill, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nathaniel Pusey

14. MOTHER'S MAIDEN NAME: Annie Cannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Annie R. Stuart — Address: Clementon N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Thrombosis — 30421b — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
420.1
DUE TO
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Coronary Atherosclerosis — 2 yrs.
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 22, 1957, to July 22, 1957, that I last saw the deceased alive on July 22, 1957, and that death occurred at 4 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D.
ADDRESS (Street, city or town, state): Salisbury Md
DATE SIGNED: July 22, 1957

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 25 57
22c. NAME OF CEMETERY OR CREMATORY: Christian Cemetery
22d. LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elay E. Timms
ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR
DATE

24b. REGISTRAR'S SIGNATURE: Mary N Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7995 — 08003 Reg. Dist. No. 334

1 FOR STATE HEALTH DEPT.

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23

2

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York — b. COUNTY: Bronx
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New York City 69x-3
d. STREET ADDRESS: 210 W. 145th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Lewis — Last: Redd
4. DATE OF DEATH: Month: 7 — Day: 27 — Year: 1957
5. SEX: M
6. COLOR OR RACE: A,A.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/4/1926
9. AGE (In years last birthday): 30 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY: Transport
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: William Redd
14. MOTHER'S MAIDEN NAME: Jeanette Baugham
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: James L. Perkins — Address: 210 W. 145th St. N.Y.N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed skull — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
8162
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in car that collided with a trailer truck.
20c. TIME OF INJURY: Month, Day, Year: Hour: 5:30 o. m. p. M. 7-27-57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): R F D # 13
20f. (City or town): Pocomoke — (County): Worcester — (State): Md.
21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7-29-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-1-57
22c. NAME OF CEMETERY OR CREMATORY: Frederick Douglas Cemetery
22d. LOCATION (City, town, or county): Staten Island — (State): N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. F. STEWART Salisbury Md
24a. RECORDER REGISTRAR — DATE: JUL 31 1957
24b. REGISTRAR'S SIGNATURE: Mary K. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07996 **CERTIFICATE OF DEATH** 08004 Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Private Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Resident prior to admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton 05x02
d. STREET ADDRESS: 319 S. 2nd St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First FRANCIS — Middle IRVING — Last REYNOLDS

4. DATE OF DEATH: Month JULY — Day 16 th — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 15, 1868
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U.S. Rubber Employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Middletown, Delaware
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Reynolds
14. MOTHER'S MAIDEN NAME: Mary Rothwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. William A. Reynolds (Son) Address: 45 Uclid Ave. Cleveland 3, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
442x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-11, 1957 to 7-16, 1957 that I last saw the deceased alive on 7-16-57, 19, and that death occurred at 10:25P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip A Insley M.D. ADDRESS (Street, city or town, state): Salisbury, Md DATE SIGNED: 7-17-57

PHYSICIAN'S NAME (Type): Dr. Philip A. Insley — 116 E. Main St. Salisbury, Md. July 17/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 19, 1957
22c. NAME OF CEMETERY OR CREMATORY: Drawyer's Cemetary
22d. LOCATION (City, town, or county) (State): Near Odessa Delevare

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: JUL 19 1957
24b. REGISTRAR'S SIGNATURE: Mary W Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7997 **CERTIFICATE OF DEATH**

08005 Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: D

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY: Camden
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Haddonfield
d. STREET ADDRESS: 454 Elm ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clayton — Middle: J. — Last: Richardson

4. DATE OF DEATH: Month: July — Day: 19 — Year: 1957

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 28 1872

9. AGE (In years last birthday): 84 11/12 yrs.

IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Banker

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Snow Hill Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Oliver J. Richardson

14. MOTHER'S MAIDEN NAME: Mary F. Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-07-6244

17. INFORMANT: Mr Walden J. Richardson — Address: Haddonfield N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — 454 Elm ave
DUE TO (b): Myocardial Infarction
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 434.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/19, 1957 to 7/19, 1957, that I last saw the deceased alive on 7/19, 1957, and that death occurred at 1:35 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas L. Jones, M.D. — ADDRESS (Street, city or town, state): 512 E. Market St. Snow Hill, Md. — DATE SIGNED: 7/19/57

PHYSICIAN'S NAME (Type): —

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: July 21/57 — 22c. NAME OF CEMETERY OR CREMATORY: Whaleyville Cemetery — 22d. LOCATION (City, town, or county) (State): Snow Hill, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elmer E. Timms — ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR — DATE: JUL 22 1957 — 24b. REGISTRAR'S SIGNATURE: Margaret Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07998

08006 332

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 614 Westover Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: E.; Last: Robinson

4. DATE OF DEATH: Month: July; Day: 17; Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1887

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Ellis

14. MOTHER'S MAIDEN NAME: Annie Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): –

16. SOCIAL SECURITY NO.: 219-05-3645A

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Recurrent cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ?

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis, general — ?

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 422.1 Arteriosclerotic cardiovascular disease, decompensated

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 15, 1957, to July 17, 1957, that I last saw the deceased alive on July 17, 1957, and that death occurred at 9:45A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr V. Juerman M.D.

ADDRESS (Street, city or town, state): Deer's Head State Hospital

DATE SIGNED: 7/17/57

PHYSICIAN'S NAME (Type): V. Juerman, M. D.

Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-19-57

22c. NAME OF CEMETERY OR CREMATORY: Deer's Head Cem

22d. LOCATION (City, town, or county) (State): Salisbury Md. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Baker & Mech

ADDRESS: 130 Second Street, Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 22 1957

24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7999 **CERTIFICATE OF DEATH**

08007 Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton
d. STREET ADDRESS: 209 N. 4th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE; Middle --; Last ROSS

4. DATE OF DEATH: Month July; Day 30; Year 19 57

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 12, 1887

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: House Carpenter

11. BIRTHPLACE (State or foreign country): Denton, Maryland RFD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis Ross

14. MOTHER'S MAIDEN NAME: Irene Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) --

16. SOCIAL SECURITY NO. --

17. INFORMANT Address: Deer's Head Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: ?
177X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pyelonephritis — ?
DUE TO
(c) Ca. of prostate gland with advanced metastases — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 442X Arteriosclerotic Cardiovascular Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 29, 19 57, to July 30, 19 57, that I last saw the deceased alive on July 30, 19 57, and that death occurred at 4:55A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. V. Juerman M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 7/30/57

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Deer's Head State Hospital

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: August 3, 1957
22c. NAME OF CEMETERY OR CREMATORY: Ross Chapel Cemetery
22d. LOCATION (City, town, or county) (State): Near Federalsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J.J. Frampton Son — ADDRESS: Federalsburg Md.

24a. REC'D BY REGISTRAR DATE: 8-1-57

24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08000

CERTIFICATE OF DEATH

08008 337

Reg. Dist. No.

1 M

I 82

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Delmar
d. STREET ADDRESS: RFD 3 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marion — Middle: Edna — Last: Roswell

4. DATE OF DEATH: Month: July — Day: 15 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 26, 1891

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Robins

14. MOTHER'S MAIDEN NAME: Unknown Frink

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --------

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Paul Roswell, Delmar, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

260 x

DUE TO (b): Arteriosclerosis of Coronary Arteries

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Diabetes Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 420.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 30, 19 57 to July 14 19 57 that I last saw the deceased alive on July 14, 19 57, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr Carrie I Hearn M.D. — ADDRESS (Street, city or town, state): 226 N Division St Salisbury Md — DATE SIGNED: 7/17/57

PHYSICIAN'S NAME (Type): Dr CARRIE I HEARN — 226 N. Division St Salisbury Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-17-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive

22d. LOCATION (City, town, or county) (State): Delmar, Del

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. S. Mann Co Delmar, Del

24a. REC'D BY REGISTRAR DATE: JUL 22 1957

24b. REGISTRAR'S SIGNATURE: Mary A. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08025 **CERTIFICATE OF DEATH** 08009

Reg. Dist. No. 335

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
c. LENGTH OF STAY IN 1b: 59 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Main Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
d. STREET ADDRESS: Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: Edward; Last: Russell

4. DATE OF DEATH: Month: July; Day: 4; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 30, 1897

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bridge Tender

10b. KIND OF BUSINESS OR INDUSTRY: Bridge

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ringold Russell

14. MOTHER'S MAIDEN NAME: Margaret Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---------

16. SOCIAL SECURITY NO.: 239-20-4294

17. INFORMANT: Mary Russell, Sharptown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3, 1957, to July 4, 1957, that I last saw the deceased alive on July 4, 1957, and that death occurred at 9 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H.S. Kuhlman M.D. ADDRESS (Street, city or town, state): Sharptown Md DATE SIGNED: 7/5/57

PHYSICIAN'S NAME (Type): H.S. Kuhlman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-7-57

22c. NAME OF CEMETERY OR CREMATORY: Riverton,

22d. LOCATION (City, town, or county) (State): Riverton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles W. Ward ADDRESS: Sharptown Md

24a. REC'D BY REGISTRAR DATE: JUL 8 1957

24b. REGISTRAR'S SIGNATURE: Mary Owens

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08001

CERTIFICATE OF DEATH

08010 337

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PEN. GEN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WOR
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY 23x2.2
d. STREET ADDRESS: DIV. ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: Patty — Last: Scott

4. DATE OF DEATH: Month: July — Day: 7 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 6, 1883

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED P.O. EMPLOYEE

10b. KIND OF BUSINESS OR INDUSTRY: U.S.P. OFFICE

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: POWELL PATTEY

14. MOTHER'S MAIDEN NAME: VIRGINIA BOSTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT Address: MRS. MILDRED CARMINE, RYDAL PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/9/, 1957, to 7/7/57, 19____, that I last saw the deceased alive on July 7, 1957, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Scott Ellis Jr. M.D.
ADDRESS (Street, city or town, state): Salisbury Md
DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/10/57
22c. NAME OF CEMETERY OR CREMATORY: ST. PAULS
22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Anna R. Burbage Berlin Md

24a. REC'D BY REGISTRAR DATE: JUL 11 1957
24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08002

CERTIFICATE OF DEATH

08011 337

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 7½ months
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton 21602
d. STREET ADDRESS: RFD 2 - Box 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rachel; Middle: ; Last: Scott

4. DATE OF DEATH: Month: July; Day: 23; Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/10/18 98 ?

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 14 days
DUE TO
(b): Arteriosclerosis, general — ?
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 4200 Hypertensive arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m.; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 3, 1956, to July 23, 1957, that I last saw the deceased alive on July 23, 1957, and that death occurred at 4:35P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: V Juerman M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 7/24/57

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/27/57
22c. NAME OF CEMETERY OR CREMATORY: Carmichael Cem
22d. LOCATION (City, town, or county) (State): Queenstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James R Bodnell, Easton, Md — ADDRESS:

24a. REC'D BY REGISTRAR — DATE: AUG 6 1957
24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9,14 FilmG128 7-18-57 et

08012

CERTIFICATE OF DEATH

08003

Reg. Dist. No. 338

90

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springhill Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 SALISBURY
d. STREET ADDRESS: Springhill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Virginia Middle: ELEANOR Last: Sinnamon

4. DATE OF DEATH Month: July Day: 9 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCT. 22, 1872
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): BERLIN MD R.F.D.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: JOHN SMITH
14. MOTHER'S MAIDEN NAME: ~~UNKNOWN~~ Erexine Littleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No NO (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: MR WILLIAM SINNAMON Address: OCEAN CITY, MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.
492X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Bronchitis, Pulmonary Emphysema, Cor Pulmonale
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ (WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): 502.0
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that I attended the deceased from 6-14-55, 19___, to 7-9, 1957, that I last saw the deceased alive on 7-8-, 1957, and that death occurred at 11:05 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. ADDRESS (Street, city or town, state): Salisbury, Md. DATE SIGNED: July 9, 1957
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/13/57
22c. NAME OF CEMETERY OR CREMATORY: MT. MORIAH
22d. LOCATION (City, town, or county): PHILADELPHIA (State): PA.

23. FUNERAL DIRECTOR'S SIGNATURE: Emma H. Burbage ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: JUL 11 1957
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

6

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C8004

CERTIFICATE OF DEATH

08013 331

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 507 Lincoln Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Quantico
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle ANN — Last SMITH

4. DATE OF DEATH: Month July — Day 25 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/16/1874

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days 9
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: John Smith

14. MOTHER'S MAIDEN NAME: Rebecca

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: ------

17. INFORMANT — Address: Paul Smith, 507 Lincoln Ave., Salisbury

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 24th 1957, to July 24th 1957, that I last saw the deceased alive on July 24th 1957, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William Emrich M.D. — ADDRESS (Street, city or town, state): Hebron, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): William Emrich — Hebron, Maryland — 7/26/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/27/57

22c. NAME OF CEMETERY OR CREMATORY: Hebron Cem.

22d. LOCATION (City, town, or county) (State): Hebron, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. D. Messick — ADDRESS: Bivalve, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 6 1957

24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C8026 — 08014 331 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Willards
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D.#

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X / Willards (Rural)
d. STREET ADDRESS: / R.D.#
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
SADIE	MAE	SMITH	JULY	24th	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	May 3, 1911	46 yrs.	2	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House work	None	R.D.# Salisbury, Maryland	U S A

13. FATHER'S NAME: William Marion Reddish
14. MOTHER'S MAIDEN NAME: Sarah Ann Causey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Mr. Clarence E. Reddish (Brother) Willards Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carbon-monoxide poisoning — INTERVAL BETWEEN ONSET AND DEATH: Sudden.

973.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Garden hose attached to exhaust running in window of a car.

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work [ ] Not while at work [X]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
2:20 P.M.	7-24 1957		Home	Willards	Wicomico	Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Dr. Earl L. Royer
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: July 26 1957

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 27, 1957	Spring Hill Memory Gardens	Near Hebron, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.	JUL 29 1957	Mary Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08015 332

C8027 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bivalve c. LENGTH OF STAY IN 1b: Lifetime d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bivalve d. STREET ADDRESS: / e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Elwood	Middle: S.	Last: Somers	4. DATE OF DEATH	Month: July	Day: 19	Year: 1957	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 2/2/1872	9. AGE (In years last birthday): 85 yrs.	IF UNDER 1 YEAR: Months: 5	Days: 17	IF UNDER 24 HRS.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter	10b. KIND OF BUSINESS OR INDUSTRY: Ship Carpenter	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: George Somers		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----	16. SOCIAL SECURITY NO.	17. INFORMANT: Nellie Hopkins — Address: Mount Vernon, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week

332 x

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b): Generalized Arteriosclerosis — 5 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 18 Aug, 1947, to 19 July, 1957, that I last saw the deceased alive on 19 July, 1957, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H. Saunders M.D. — ADDRESS (Street, city or town, state): Nanticoke Md — DATE SIGNED: 7/20/57

PHYSICIAN'S NAME (Type): Richard H. Saunders — Nanticoke, Maryland — 7/20/57

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7/20/57	Turner's Cem.	Nanticoke, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
C. D. Messick	Bivalve, Maryland	JUL 26 1957	Mary T. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08005

CERTIFICATE OF DEATH

08016

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Mardela
d. STREET ADDRESS: Rt. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: Sharletta — Last: Stanley

4. DATE OF DEATH: Month: July — Day: 11 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 26, 1896

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Bridgeville, Del.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Fisher

14. MOTHER'S MAIDEN NAME: Alberta Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-32-5177

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Inoperable Ca. of cervix uteri with generalized

DUE TO: metastases.

171x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/2/ 1957 to 7/11/ 1957, that I last saw the deceased alive on 7/11/ 1957, and that death occurred at 8:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Jverman. M.D.

ADDRESS (Street, city or town, state): Deer's Head State Hospital

DATE SIGNED: 7/12/57

PHYSICIAN'S NAME (Type): V. Jverman, M. D.

Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 13,1957

22c. NAME OF CEMETERY OR CREMATORY: Zion Church Cemetery

22d. LOCATION (City, town, or county) (State): Near Sharptown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J.J.Frampton and Son, Federalsburg, Maryland

ADDRESS

24a. REC'D BY REGISTRAR DATE: 7-15-57

24b. REGISTRAR'S SIGNATURE: Marylu Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08996

CERTIFICATE OF DEATH

08017 33r
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 304 E. Vine St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGIE Middle SMITH Last SULLIVAN

4. DATE OF DEATH: Month JULY Day 13 th Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 22, 1893
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months 9 Days 21
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Shad Point, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: David Fields
14. MOTHER'S MAIDEN NAME: Alverta Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. George E. Sullivan Jr. (Son) Address: 304 E. Vine St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Complete heart block — INTERVAL BETWEEN ONSET AND DEATH: Delay
420.0
DUE TO
(b): arteriosclerotic heart disease — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
434.1 Congestive heart failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/1, 19 57, to 7/12, 19 57, that I last saw the deceased alive on 7/12 19 57 and that death occurred at 7:25A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Beardsley M.D.
ADDRESS (Street, city or town, state): Maryland Ave. Salisbury, Md.
DATE SIGNED: July 15 57
PHYSICIAN'S NAME (Type): Dr. Earl Beardsley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 16, 1957
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: JUL 17 1957
24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08007 | Reg. Dist. No. 08018 334

1. PLACE OF DEATH
a. COUNTY: Wicomico | MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deers Head State Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland | b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 104 Chestnut St. (West)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas | Middle: Beachamp | Last: Taylor
4. DATE OF DEATH: Month: July XX. | Day: 31 st | Year: 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Nov. 28, 1891
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: 8 | Days: 3
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick Layer-Plaster (Retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mardela, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George W. Steele Taylor
14. MOTHER'S MAIDEN NAME: Nettie Wingate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Virginia D. Lee (Daughter) Address: #10 Benjamin Ave Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): 902.7
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 4341 Fractured right hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell from bed and fractured right hip.
20c. TIME OF INJURY: Hour a. m. p. m. | Month, Day, Year: 7-20-57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital
20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D. | CHIEF MEDICAL EXAMINER ☐ | ASSISTANT MEDICAL EXAMINER ☐ | DEPUTY MEDICAL EXAMINER ☒ | DATE SIGNED: 8-1-57
EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 3, 1957
22c. NAME OF CEMETERY OR CREMATORY: Mardela Cemetery
22d. LOCATION (City, town, or county) (State): Mardela, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS: Holloway & Co. Salisbury, Maryland.
24a. REC'D BY REGISTRAR DATE: AUG 5 1957
24b. REGISTRAR'S SIGNATURE: Mary Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08008 **CERTIFICATE OF DEATH** 08019

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 406 Park Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAUD Middle LATTA Last TODD

4. DATE OF DEATH: Month 7 Day 12 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 23, 1885
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James D. Latta
14. MOTHER'S MAIDEN NAME: Elizabeth Spann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mr. S. Houston Todd, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Peritonitis	1 day
DUE TO (b)	Ruptured Diverticulum (colon)	"
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 578x 4437 — DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive Heart Disease; Chronic Bronchitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 28, 1948, to July 12, 1957, that I last saw the deceased alive on July 12, 1957, and that death occurred at 10:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. ADDRESS (Street, city or town, state): Salisbury, Maryland DATE SIGNED: 7/13/57

PHYSICIAN'S NAME (Type): Dr. David J. Gilmore, Medical Center, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/15/1957
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Hill & Johnson Co. Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE: 7-16-57
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

Norman F. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08020 337 Reg. Dist. No.

08009

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Salisbury
d. STREET ADDRESS: R.D.# 2 (Spring Hill Rd)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DAVID — Middle ELTON — Last TOWNSEND
4. DATE OF DEATH: Month JULY — Day 11 th — Year 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 7,1937
9. AGE (In years last birthday): 19 yrs. — IF UNDER 1 YEAR: Months 8 — Days 4 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk (Employee)
10b. KIND OF BUSINESS OR INDUSTRY: A. & P. Store
11. BIRTHPLACE (State or foreign country): Salisbury,Md. Pen.Gen.Hosp.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Gilbert R. Townsend
14. MOTHER'S MAIDEN NAME: Sallie Priscilla Darby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Mrs.Sallie P.Townsend(Mother)R.D.# 2 Spring Hill Road - Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured aorta and ruptured diaphragm — INTERVAL BETWEEN ONSET AND DEATH: 3 hours.
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in a car that overturned.
20c. TIME OF INJURY: Hour 12:10 a. m. ☐ p. m. ☐ — Month, Day, Year 7-11-57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway.
20f. (City or town) Salisbury (County) Wicomico (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: July 12 1957
EXAMINER'S NAME (Type): Dr. Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 14,1957
22c. NAME OF CEMETERY OR CREMATORY: Spring Hill Memorial Gardens -Near Hebron, Maryland
22d. LOCATION (City, town, or county) (State):
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: JUL 15 1957
24b. REGISTRAR'S SIGNATURE: Mary A. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08021

08010 # CERTIFICATE OF DEATH

Reg. Dist. No. 332

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The both copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

STREET ADDRESS (If rural give location): 606 Light St.

3. NAME OF DECEASED (Type or Print): (First) ANNIE (Middle) RUTH (Last) TRUITT

4. DATE OF DEATH: (Month) JULY (Day) 4 th (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Single	Oct. 6, 1905	51 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Pittsville, Maryland	U S A

13. FATHER'S NAME: Hiram James Truitt

14. MOTHER'S MAIDEN NAME: Martha Emma Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No — (If Yes, give wer or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr. Charles J. Truitt (Brother) Pemberton Salisbury, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0 IMMEDIATE CAUSE (A) Portal Cirhosis — INTERVAL BETWEEN ONSET AND DEATH: yr.

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-3-57	Portal Cirhosis	YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21e. INJURY OCCURRED While at work [ ] Not while at work [ ] — 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-29, 19 57, to 7-4, 19 57, that I last saw the deceased alive on 7-4, 19 57, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

SIGNATURE Dr. Earl L. Royer — M.D. — ADDRESS (Street, city, town, state) Camden Ave. Salisbury, Maryland — DATE SIGNED July 5 /57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial-	July 7, 1957	Pittsville Cemetery	Pittsville, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JUL 8 1957	Mary H. Holloway	HOLLOWAY & COMPANY - SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08011

CERTIFICATE OF DEATH

08022

Reg. Dist. No. 33Y

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Bivalve
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Troy — Middle: T. — Last: Vickers

4. DATE OF DEATH: Month: July — Day: 21 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/19/1890

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: 6 — Days: 2
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Allen, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles C. Vickers

14. MOTHER'S MAIDEN NAME: Heath

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO
(b): Arteriosclerotic heart disease, decompensated — ?

DUE TO
(c): — ?

420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 350 X Parkinson Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 18, 1957, to July 21, 1957, that I last saw the deceased alive on July 21, 1957, and that death occurred at 7:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Kosmahly M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 7/22/57

PHYSICIAN'S NAME (Type): G. Kosmahly, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/23/57
22c. NAME OF CEMETERY OR CREMATORY: Oak Grove Cem
22d. LOCATION (City, town, or county) (State): Jesterville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. H. Messick — ADDRESS: Bivalve, Maryland

24c. REC'D BY REGISTRAR DATE: JUL 26 1957

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08023

08012

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Hr.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 436 Monticello Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle HOWARD Last WALLER

4. DATE OF DEATH: Month 7 Day 26 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1884

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Road Building

10b. KIND OF BUSINESS OR INDUSTRY: Contracter

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Franklin Waller

14. MOTHER'S MAIDEN NAME: Fannie Wingate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 217-10-3994

17. INFORMANT: Mrs. Florence Ellis Waller, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction	
420.1 DUE TO (b)	Coronary Occlusion	7 days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Coronary Arteriosclerosis.	1 year +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 19, 1957, to July 26, 1957, that I last saw the deceased alive on July 26, 1957, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D.
ADDRESS (Street, city or town, state): 224 N. Division St. Salisbury, Md.
DATE SIGNED: 7/26/57

PHYSICIAN'S NAME (Type): Dr. Thomas C. Hill Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/28/57

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Norman T. Baker
ADDRESS: The Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: 7-27-57

24b. REGISTRAR'S SIGNATURE: Maryll. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08024

C8913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia 75x-3
d. STREET ADDRESS: 4317 Fairmount Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First — Middle — Last: Waters
4. DATE OF DEATH: Month: July — Day: 7th — Year: 1957

5. SEX: Girl
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 7th 1957
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ~~Lewis James Waters~~ ERROR
14. MOTHER'S MAIDEN NAME: Thelma Elizabeth Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Lewis James Waters - uncle

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Placental Abruption — INTERVAL BETWEEN ONSET AND DEATH

761.0

DUE TO (b): Aspiration of Blood & — 10 mins

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Amniotic Fluid.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-7, 1957, to 7-7, 1957, that I last saw the deceased alive on 7-7, 1957, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William H Koonce Jr. M.D. — ADDRESS (Street, city or town, state): PCH — DATE SIGNED:

PHYSICIAN'S NAME (Type): William Koonce, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-8-57
22c. NAME OF CEMETERY OR CREMATORY: Boggs Cemetery
22d. LOCATION (City, town, or county) (State): St Lukes, Som. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis James Waters — ADDRESS:
24a. REC'D BY REGISTRAR DATE: 7-18-57
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

5000VVVXVV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G218 8-5-57 et

08014 08025

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 20 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION G. B. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Md — b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Frank Middle: Lost: White

4. DATE OF DEATH Month: July Day: 25 Year: 1957

5. SEX Male

6. COLOR OR RACE Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 9-2-10

9. AGE (In years last birthday) 46 47 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) VA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO

16. SOCIAL SECURITY NO. 231-07-9234

17. INFORMANT Francis White — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema.
DUE TO (b) Left ventricular failure
DUE TO (c) Hypertensive C.V. disease

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Dr Gilmore has attended about past 3 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/25/57 to 7/25/57, that I last saw the deceased alive on 7/25/57, and that death occurred at 1:22 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D. — ADDRESS (Street, city or town, state) 211 Maryland Ave. Salisbury, Md. — DATE SIGNED 7/29/57

PHYSICIAN'S NAME (Type) O. J. BURTON.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 7-- 57

22c. NAME OF CEMETERY OR CREMATORY Bivalve Parsons Mem Pk

22d. LOCATION (City, town, or county) (State) Salisbury Md

23. FUNERAL DIRECTOR'S SIGNATURE Parker McCurdy — ADDRESS

24a. REC'D BY REGISTRAR DATE AUG 1 1957

24b. REGISTRAR'S SIGNATURE Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08028 **CERTIFICATE OF DEATH** 08026 332

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bridge St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Mardela
d. STREET ADDRESS: 1 Bridge St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARION — Middle WILLIAM — Last WILKINSON

4. DATE OF DEATH: Month JULY — Day 25 th — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 25,1897

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months 11 — Days 0
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman - Seaford Garment Co.(Shirt Factory)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mardela, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Wilkinson

14. MOTHER'S MAIDEN NAME: Lillie Seabrease

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs.Laura T.Wilkinson(Wife) Address: Bridge St. Mardela, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myelogenous Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
204.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/1, 19 57, to last, 19 ____, that I last saw the deceased alive on 7/24, 19 57, and that death occurred at 11:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest Larmore M.D. — ADDRESS (Street, city or town, state): 100 Grove Delmar, Del. — DATE SIGNED: 7/26/57

PHYSICIAN'S NAME (Type): Dr. Ernest M. Larmore — Delmar, Delaware — July 26 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 28,1957
22c. NAME OF CEMETERY OR CREMATORY: Mardela Cemetery
22d. LOCATION (City, town, or county) (State): Mardela, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. RECD BY REGISTRAR — DATE: JUL 30 1957 — REGISTRAR'S SIGNATURE: Thos. W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C8029 **CERTIFICATE OF DEATH** 08027

Reg. Dist. No. 334

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: In Village

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Parsonsburg
d. STREET ADDRESS: 1 In Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEONARD Middle COOPER Last WILLIAMSON

4. DATE OF DEATH: Month JULY Day 14 th Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 4, 1901

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR Months 0 Days 10 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bridgeville, Delaware

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Mitchell Williamson

14. MOTHER'S MAIDEN NAME: Anne Elizabeth Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Elizabeth P. Williamson (Wife) Address: Parsonsburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min

420.1

DUE TO (b):

Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-7-50, 19____, to 7-14, 1957, that I last saw the deceased alive on 7-13-57, 19____, and that death occurred at 10:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred R. Gramse M.D. ADDRESS (Street, city or town, state): Salisbury, md DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Fred Gramse S. Division St. Salisbury, Maryland July 16/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 17, 1957

22c. NAME OF CEMETERY OR CREMATORY: Parsohsburg, Cemetery

22d. LOCATION (City, town, or county) (State): Parsonsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: JUL 18 1957

24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08015

CERTIFICATE OF DEATH

08028

Reg. Dist. No. 332

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 32 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 208 New York Ave.,

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 208 New York Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVA; Middle; Last WIMBROW

4. DATE OF DEATH: Month 7; Day 28; Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 12,1886

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Sec.

10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John M. Wimbrow

14. MOTHER'S MAIDEN NAME: Eliza Isabell Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-05-0564

17. INFORMANT: Mrs. John Melson, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
420.1
DUE TO
(b): Atherosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: Dr GRANSE has been attending for 15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
422.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/28/ 19 57, to 7/28/ 19 57, that I last saw the deceased alive on 7/28/ 19 57, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Salisbury, Maryland

DATE SIGNED: 7/ /1957

PHYSICIAN'S NAME (Type): Dr. O.J. Burton 211 Maryland Ave., Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/30/57

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: 7-30-57

24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

Norman D. Baker

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08030

CERTIFICATE OF DEATH

08029 337

Reg. Dist. No.

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardella c. LENGTH OF STAY IN 1b: Life time	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Mardella
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS: Rt #2 Delmar, Del. e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Nancy	Braxton	Winder	7	25	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F. M.	AA		March 2, 1908	49 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	Home	Essex Co , Va.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Matthew Braxton	Selina Gaines

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Isaac Winder, Rt#2 Delmar, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease with cerebral embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 month

416 X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 332X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/20, 1957, to 7/25/57, that I last saw the deceased alive on 7/23, 1957, and that death occurred at 1 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest M. Larmore M.D. ADDRESS (Street, city or town, state): Delmar, Del DATE SIGNED: 7/25/57

PHYSICIAN'S NAME (Type): E M Larmore Delmar, Del

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7-27-1957	Mt. Nebo Cemetery	Columbia, Del

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
J. F. Stewart Funeral Home, Salisbury, Md.	JUL 31 1957	Mary H. Holloway